Executive Committee
RI Healthcare Reform Commission
Monday 16 May 2011
Department of Administration, Conference Room C

I. Call to Order – The Lt. Governor called the meeting to order at 2:05pm. Acknowledgements of all those who contributed to the planning of today's meeting which will include a detailed presentation of the Health IT Initiative

II. Discussion and Presentation of Health IT (hereafter HIT) Initiatives

a. Common examples of HIT: Electronic medical records, personal health records, health information exchange, public health, quality and claims databases, and eligibility systems. There was a brief overview of Health Information acronyms. Jennifer Wood, Office of the Lieutenant Governor, provided a brief overview of electronic health records, public and private systems. Note - currentcare, (at RIQI) is the public state level exchange. Lifespan and BVCHC (Blackstone Valley Community Health Center) have private records exchanges. Some personal health record systems are also available to Rhode Islanders, such as E.R. Card, Googlehealth, HealthVault, etc.

b. Amy Zimmerman began presenting on Clinical Data Exchange in RI – these are methods for moving many types of information from point A and point B. The idea would be for data to transfer into currentcare, as well as exchange with the patient,

c. Electronic Health Record Adoption – 2011 RI Adoption Rates 51% of physicians adopted E.H.R., and 17% have adopted a "qualified E.H.R." (in other words an EHR that meets federal requirements for financial support for its establishment from the federal government). This data is from a 2011 HIT Survey. 2010 Hospital E.H.R. rates, 77% of hospitals had fully implemented E.H.R., another 8% had partially implemented E.H.R. What is being measured here is what physicians are implementing in their office – provider's medical record on their patient (*not* an interoperable record that can be shared, nor a patient level "personal" health record.)

d. Important clarification – E.M.R.: Electronic Medical Record, similar to paper medical record in a hospital and a doctor's office. An E.H.R., electronic health record is more of a longitudinal record, originally across multiple providers, labs etc. The policy goal is to implement full EHR.

e. Practices must meet "meaningful use" standards to receive funding incentives. Rules differ for Medicaid and Medicare funding, therefore state Medicaid programs need to build registration, payment and audit systems to manage incentives; providers must produce a set of clinical quality measures.

The question was posed if the federal government also paid for the Medicaid program to implement these incentives. The answer was yes, at a 90:10 match. In order for the practice to receive the Medicaid E.H.R. incentive - a pediatrician for example - would need to have at least 20%

Medicaid patients. The definition of 'meaningful use is essentially the same for both Medicare and Medicaid."

f. Thus far, electronic-prescribing, has been a great success with 100% of RI pharmacies able to receive electronic prescriptions. As for the status of Laboratory and Other Data Sharing in RI, 50% of labs were able to send lab results electronically.
g. Funding/Incentives for E.H.R. adoption – E.H.R. incentive program (Medicare& Medicaid) $44K - $64K of federal incentive funds per provider who adopts and "meaningfully uses" an E.H.R worth approx 18 million overall. RI Medicaid will begin registering eligible providers and hospitals in the next two months, and expect to pay out incentives this summer. Other insurers providing incentives are Blue Cross and Blue Shield of Rhode Island (hereafter BCBSRI) United Healthcare, Tufts, and Medicaid Connectcare. According to the Affordable Care Act, in 2015 there will be penalties if there is not an E. H.R. established. Other efforts to drive the E. H.R. adoption are the regional extension center, patient centered medical home initiatives, and community based job training for certified E. H.R. professionals.

h. currentcare – RI Electronic health information exchange currently has 148,000 enrolled in currentcare. East Side Clinical labs are sending lab results, to match rate at 15%, with three more data sharing partners implemented in June, implement access to medication history data, pilot continuity of care document from an E.H.R. to currentcare in next few months, working with long term care facilities to enroll residents & provide computers to access HIE. Funding for RI HIE currentcare started with AHRQ funds to the Department of Health ($5 million over past 6 years), Medicaid Transformation Grant ($2 million), ARRA State HIE Grant ($5.2M), and other private funds. Other RIQI HIT projects – Regional Extension Center, Beacon Community Effort. Two outstanding issues –what is the state's role vis-à-vis funding strategy to operate/maintain and expand HIE. Also what is the state's role vis-à-vis developing a logical statewide approach/system given propensity towards implementation of proprietary systems.

i. Personal Health Records: some private options already are an ER card, charged on a monthly fee, and are flash drive based. Googlehealth is a free of charge "cloud based" compilation of a patients medical record, like Microsoft HealthVault. These are controlled by the patient, are password protected and are shared with providers at patient discretion. This is a big question mark in this environment; different providers would have to subscribe to upload their data, as most patients do not have their total medical records to input right away.

j. Elena Nicolella presented on Data Systems to support publicly funded health care: Medicaid Management Information System (hereafter MMIS) is Medicaid's mechanized claims processing and information retrieval system. Funds from the federal government are 90% of expenditures for design, development or installation of mechanized claims procession and info retrieval, and 75% of expenditures of operation of the system.

   The ACA requires new business processes to be adopted – operate seamlessly with HIE, participate in a system to verify info from applicants electronically, incorporate a streamlined application for multiple sources of coverage and health insurance assistance. The challenge is to break off the electronic eligibility systems for Medicare and the Exchange from human service programs, and then reintegrate those other human service programs back into the newly created electronic system.

   The federal government will provide 90% of funding available for design, development and installation or enhancement of eligibility determination systems until December 31, 2015 - note that with Exchange monies, the state is looking at a 95% federal government match. Other relevant resources: Ford Foundation Modernization Grant ($250K), RWJF Exchange Implementation Grant ($1M tech assistance) Federal Innovator Grant ($25M to UMASS consortium, including RI). The EOHHS Data Warehouse integrates data from multiple state agencies and provides a common reporting infrastructure.

k. HIE Exchange Portal – Angela Sherwin, Office of the Health Insurance Commissioner (hereafter OHIC), presented on the HIE Exchange Portal. The exchange authority once established will serve as the entry point for RI seeking health coverage in 2014 and beyond, technical architecture and requirements to be determined in the next six months.

l. Public Health, Cost, and Quality Databases – Presentation by Sam Viner (Dept. of Health). Databases by various categories and these databases interact through partnership: Data collection -> data management -> data analysis -> reporting/dissemination -> program policy decision making, back to full circle. Not just about collection, but interaction. The data is used to look at the health status of RI, disease prevalence, to evaluate programs, to do needs assessments, to identify risk factors, and determine quality of care. Examples are: KIDSNET Data Sources, Hospital Discharge & ED Visit Database (includes all individual regardless of age or residency admitted as inpatients or treated in an Emergency Department or Observation Unit in a hospital in RI). Some of the data is integrated into the EOHHS database, where continuing work is being done.

m. All Payer Claims Database – Tricia Leddy. All Payer Claims Database (hereafter APCD) is a new database that does not exist in RI yet. APCD is

a large, statewide database that systemically collects health care claims data from both private and public payers. In 2008 the RI Department of Health was statutorily authorized to establish and maintain an APCD, which directs private and public payers to submit claims for health services (not yet funded, thus not yet enacted). APCD is designed to improve transparency of info about health care use and price, inform state health care policy, and improve understanding of quality, efficiency and costs of health care in RI. It will not include data regarding uninsured individuals, and will not include personal identifiers, but will include the self insured (done in other states as well as outlined in statute). APCD will be a valuable tool for many public and private agencies, including the health plans, provider groups, employers, QPRI, RIQI, medical programs, RO future HIE, health service researchers, and others.

Funding: Short term - RIQI is supporting the initial development of APCD with Beacon funded technical assistance in exchange for early access to the public APCD data in the summer of 2012.
Long term – to charge and accept fees from user to support the APCD as the statue allows, such as Medicaid, the HIE, OHIC, etc. Currently ready to decide on the technology infrastructure - three basic options, existing private vendor database infrastructure by contracting with an IT firm which already operates and houses the APCD for other states; add on to an existing state database infrastructure = OHHS's existing data warehouse infrastructure can be leveraged to host the APCD with the advantage of additional federal matching funds; build a new APCD (though this is no longer under consideration).

n. HIT Challenges for discussion – APCD, RIQI sustainability, Medicaid and Exchange Compatibility.
    i. Who will make the decisions for APCD and running it – under law, HEALTH, and there would most likely by a memo of understanding that complies with said law for other groups under OHHS to work and assist with decisions? As the data in the APCD is identified by providers and insurers, it certainly would provide more transparency. Decisions about priority uses will need to be made, looking to other states. The statute is clear the APCD is very public; it is permitted in the law that users can pay a fee for the use. There are various methods in other states for allowing access to the data - for example, large users can pull data for the researchers. A question was raised if this data can be used for data mining, and competitiveness, how do we regulate this, to ensure someone is spending all their time which people want for commercial purposes as opposed to public purposes. Once someone pays the fee and purchases the data, it is public and that individual who purchases the public portion of the data may do what they wish, as it is de-identified. The good thing is that we are

the eleventh state to put this through, and ten others have dealt with these issues prior to us.

ii. A question about the interaction between the Data Warehouse and the APCD was also raised. It was explained that the data would be segregated, there are complex design issues about how to segregate the public benefits data from the commercial payer data and still be able to provide comprehensive reports that are aggregated without any personal identifying information. The APCD will use the same infrastructure, but it would not be linked on a person specific basis. DHS by law that has the responsibility to oversee HIE. The HIT coordinator is a function that is required to receive the state HIT plan under ARRA – each state must have a HIT coordinator to ensure responsibility of coordination. Although the early development work on the APCD is being supported by grant funds obtained by the RIQI, this project will fall under the statutory authority and responsibility to DHS and DOH ultimately.

III. Exchange Update:
   a. Angela Sherwin – stated that there is now a purchase order for a planning vendor. Secondly, representatives from the interagency work group went to a meeting in Denver, and at that meeting, RI was asked to be the model for other states to discuss how we are integrating the planning process. Last week a meeting in Salt Lake to learn about Utah's exchange and how it affects small businesses.

IV. Grants Update
   a. Interesting interaction on federal level, last week, confirm the number we are seeking.
   b. RWJF, there is a site visit on Wednesday May 18 to discuss the newly awarded grant.

V. New Business: next meeting on CON Health Planning; Director Licht cannot meet on June 13.

VI. Public Comment: No public comment was offered.

VII. Adjourn